Reprinted
April 10, 2007

ENGROSSED
SENATE BILL No. 566

DIGEST OF SB 566 (Updated April 9, 2007 4:49 pm - DI 114)

Citations Affected: IC 11-12; IC 12-7; IC 12-15; IC 12-19; IC 36-2.

Synopsis: Health care services and Medicaid. Prohibits the office of Medicaid policy and planning (OMPP) or a contractor of OMPP from reducing Medicaid providers reimbursement rates if OMPP has reverted appropriated money to the state general fund during the previous state fiscal year. Requires an insurer to accept a Medicaid claim for services provided a Medicaid recipient for three years after the date the service was provided. Specifies the circumstances in which a Medicaid claim may not be denied by an insurer. States that notice requirements may be satisfied by electronic or mail submission (current law provides only for certified or registered mail). Requires an insurer to accept the state's right of recovery and assignment of certain rights as required by federal law. Adds certain less restrictive settings to the definition of children's psychiatric residential treatment services. Requires OMPP to conduct a study of the percentage of Medicaid claims eligible for payment by a third party. Provides that if the study

(Continued next page)

Effective: Upon passage; July 1, 2007.

Dillon

(HOUSE SPONSORS — BROWN C, BROWN T, WELCH)

January 23, 2007, read first time and referred to Committee on Health and Provider Services.
February 8, 2007, amended, reported favorably — Do Pass.
February 12, 2007, read second time, ordered engrossed.
February 13, 2007, engrossed. Read third time, passed. Yeas 46, nays 0.

HOUSE ACTION

March 6, 2007, read first time and referred to Committee on Public Health.
March 26, 2007, amended, reported — Do Pass. Recommitted to Committee on Ways and Means.
April 3, 2007, amended, reported — Do Pass.
April 9, 2007, read second time, amended, ordered engrossed.

Digest Continued

by OMPP reveals a percentage of 1% or above, OMPP shall implement an automated procedure for determining whether a Medicaid claim is eligible for payment by a third party before payment. Requires a county reimburse a physician, hospital, or any other health care provider for health care services provided to a person subject to lawful detention by the sheriff of the county at a rate equal to the rate in the county's health plan in which most county employees are enrolled. Provides that a sheriff may not release a person to avoid county payment for health care services. Requires a sheriff to remain at the hospital while a person being lawfully detained is treated at the hospital.

Reprinted
April 10, 2007

First Regular Session 115th General Assembly (2007)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2006 Regular Session of the General Assembly.

ENGROSSED
SENATE BILL No. 566

A BILL FOR AN ACT to amend the Indiana Code concerning health care services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 11-12-5-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 8. (a) This section does not apply to a person subject to lawful detention who:**

(1) maintains a policy of insurance from a private company covering health care services; or

(2) is willing to pay for the person's own health care services.

(b) As used in this section, "lawful detention" has the meaning set forth in IC 35-41-1-18.

(c) A county shall reimburse:

(1) a physician licensed under IC 25-22.5;

(2) a hospital licensed under IC 16-21-2; or

(3) any other health care provider;

for health care services provided to a person subject to lawful detention by the sheriff of the county. The reimbursement must be paid at a rate that is equal to the reimbursement rate that applies to health care services provided under a health care provider

network contract with the county's health plan in which the most county employees are enrolled.

(d) The reimbursement paid under this section:

(1) must be equal to the reimbursement rate that the county health plan described in subsection (c) would pay after subtracting copayment amounts that would normally apply under the plan; and

(2) may not be reduced because of any deductible amounts or similar obligations owed under the county health plan.

(e) This section may not be construed to prevent or limit the application of IC 11-12-5-5 concerning the making of copayments by a person confined to a county jail.

(f) A county that is responsible for paying the medical care expenses of a county jail inmate under IC 11-12-5-6 is responsible paying the medical care expenses of the inmate under this section.

(g) This section may not be construed to supersede a written agreement:

(1) between:

(A) a physician, a hospital, or any other health care provider; and

(B) a county or sheriff;

concerning reimbursement for health care services provided to a person subject to lawful detention; and

(2) entered into or renewed before July 1, 2007.

SECTION 2. IC 12-7-2-47.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 47.5. "Covered entity", for purposes of IC 12-15-23.5, has the meaning set forth in IC 12-15-23.5-1.**

SECTION 3. IC 12-15-13-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 4. The office or a contractor of the office may not, during a state biennial budget period, reduce the rate of reimbursement to a Medicaid provider for a service that is reimbursable under the Medicaid program if the office has reverted to the state general fund any money appropriated to the office for the Medicaid program during the previous state fiscal year.**

SECTION 4. IC 12-15-23.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 23.5. Coordination of Benefits Study

Sec. 1. As used in this chapter, "covered entity" has the meaning

set forth in 45 CFR 160.103.

Sec. 2. Before January 1, 2008, the office shall:

(1) examine all Medicaid claims paid after January 1, 2001, and before July 1, 2007; and

(2) determine the percentage of the claims examined under subdivision (1) that were eligible for payment by a third party other than Medicaid.

The office may require, and a covered entity shall provide, any information necessary for the office to complete the examination required by this section. The office, after notice and hearing, may impose a fine not to exceed one thousand dollars ($1,000) for each refusal by a covered entity to provide information under this section.

Sec. 3. If the percentage determined under section 2 of this chapter is at least one percent (1%), the office shall develop and implement a procedure to improve the coordination of benefits between:

(1) the Medicaid program; and

(2) any other third party source of health care coverage provided to a recipient.

Sec. 4. If a procedure is developed and implemented under section 3 of this chapter, the procedure:

(1) must be automated; and

(2) must provide a system for determining whether a Medicaid claim is eligible for payment by another third party before the claim is paid under the Medicaid program.

SECTION 5. IC 12-15-29-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 4.5. (a) An insurer shall accept a Medicaid claim for a Medicaid recipient for three (3) years from the date the service was provided.**

(b) An insurer may not deny a Medicaid claim submitted by the office solely on the basis of:

(1) the date of submission of the claim;

(2) the type or format of the claim form; or

(3) a failure to provide proper documentation at the point of sale that is the basis of the claim;

if the claim is submitted by the office within three (3) years from the date the service was provided as required in subsection (a) and the office commences action to enforce the office's rights regarding the claim within six (6) years of the office's submission of the claim.

(c) An insurer may not deny a Medicaid claim submitted by the

office solely due to a lack of prior authorization. An insurer shall conduct the prior authorization on a retrospective basis for claims where prior authorization is necessary and adjudicate any claim authorized in this manner as if the claim received prior authorization.

SECTION 6. IC 12-15-29-7 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 7. (a) The notice requirements of section 4 of this chapter are satisfied if:

(1) the insurer receives from the office, ~~by certified~~ **electronically** or ~~registered~~ **by United States** mail, a statement of the claims paid or medical services rendered by the office, together with a claim for reimbursement; or

(2) the insurer receives a claim from a beneficiary stating that the beneficiary has applied for or has received Medicaid from the office in connection with the same claim.

(b) An insurer that receives a claim under subsection (a)(2) shall notify the office of the insurer's obligation on the claim and shall:

(1) pay the obligation to the provider of service; or

(2) if the office has provided Medicaid, pay the office.

SECTION 7. IC 12-15-29-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 9. (a) IC 27-8-23 applies to this section.

(b) To the extent that payment for covered medical expenses has been made under the state Medicaid program for health care items or services furnished to a person, in a case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the person to payment by any other party for the health care items or services.

(c) As required under 42 U.S.C. 1396a(a)(25), an insurer shall accept the state's right of recovery and the assignment to the state of any right of the individual or entity to payment for a health care item or service for which payment has been made under the state Medicaid plan.

SECTION 8. IC 12-19-7.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this chapter, "children's psychiatric residential treatment services" means services that are:

(1) eligible for federal financial participation under the state Medicaid plan; and

(2) provided to individuals less than twenty-one (21) years of age who are:

(A) eligible for services under the state Medicaid plan;

(B) approved by the office **as eligible** for admission to and treatment in a private psychiatric residential treatment facility; and

(C) **either** residing in a:

(i) private psychiatric residential facility for the purposes of treatment for a mental health condition, based on an approved treatment plan that complies with applicable federal and state Medicaid rules and regulations; **or**

(ii) less restrictive setting and participating in a federally approved community alternatives to psychiatric residential treatment facilities demonstration grant that provides safe, intensive, and appropriate services under an approved treatment plan that complies with federal and state Medicaid law.

SECTION 9. IC 36-2-13-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ A FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 17. (a) This section does not apply to a person subject to lawful detention who:**

(1) maintains a policy of insurance from a private company covering health care services; or

(2) is willing to pay for the person's own health care services.

(b) As used in this section, "lawful detention" has the meaning set forth in IC 35-41-1-18.

(c) A sheriff of a county may not release a person subject to lawful detention solely for the purpose of preventing the county from being financially responsible under IC 11-12-5-8 for health care services provided to the person.

(d) If a county violates subsection (c), the county remains financially responsible under IC 11-12-5-8 for health care services provided to the person released from lawful detention.

(e) A county is financially responsible under IC 11-12-5-8 for medical care provided to a person at a hospital if that person was subject to lawful detention by the sheriff at the time the person entered the hospital's premises.

(f) If a person is subjected to lawful detention after entering the premises of a hospital, the county in which the hospital is located is financially responsible under IC 11-12-5-8 for the medical care provided to the person while the person is subject to lawful detention.

(g) For purposes of this section, if a sheriff brings a person subject to lawful detention onto the premises of a hospital or subjects a person to lawful detention after the person enters the

premises of a hospital, the sheriff shall remain on the premises of the hospital and within reasonable proximity to the person while the person receives medical care at the hospital unless:

(1) the person's medical condition renders the person incapable of leaving the hospital; and

(2) the person does not pose a threat to hospital personnel or property or to others at the hospital.

(h) This section may not be construed to prevent or limit the application of IC 11-12-5-5 concerning the making of copayments by a person confined to a county jail.

(i) A county that is responsible for paying the medical care expenses of a county jail inmate under IC 11-12-5-6 is responsible paying the medical care expenses of the inmate under this section.

(j) This section may not be construed to supersede a written agreement:

(1) between:

(A) a physician, a hospital, or any other health care provider; and

(B) a sheriff;

concerning reimbursement for health care services provided to a person subject to lawful detention; and

(2) entered into or renewed before July 1, 2007.

SECTION 10. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 566, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, delete lines 33 through 42, begin a new paragraph and insert:

"SECTION 4. IC 12-19-7.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this chapter, "children's psychiatric residential treatment services" means services that are:

(1) eligible for federal financial participation under the state Medicaid plan; and

(2) provided to individuals less than twenty-one (21) years of age who are:

(A) eligible for services under the state Medicaid plan;

(B) approved by the office for admission to and treatment in:

(i) a private psychiatric residential treatment facility; ~~and~~ **or**

(ii) another level of care setting; and

(C) residing in:

(i) a private psychiatric residential facility; **or**

(ii) an alternative setting;

for the purposes of treatment for a mental health condition, based on an approved treatment plan that complies with applicable federal and state Medicaid rules and regulations.".

Delete page 3.

and when so amended that said bill do pass.

(Reference is to SB 566 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 566, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-15-13-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 4. The office or a contractor of the office may not, during a state biennial budget period, reduce the rate of reimbursement to a Medicaid provider for a service that is reimbursable under the Medicaid program if the office has reverted to the state general fund any money appropriated to the office for the Medicaid program during the previous state fiscal year.**

SECTION 2. IC 12-15-13-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 5. (a) Notwithstanding any other law, the office or a contractor of the office shall accept a Medicaid claim for a Medicaid recipient, including a Medicaid waiver recipient, for a service that is reimbursable under the Medicaid program for the Medicaid recipient for three (3) years after the date the service was provided.**

(b) The office or a contractor of the office may not deny a Medicaid claim submitted by the office solely on the basis of:

(1) the date of submission of the claim;

(2) the type or format of the claim form; or

(3) a failure to provide proper documentation at the point of sale that is the basis of the claim;

if the claim is submitted by the Medicaid provider within three (3) years after the date the service was provided as required in subsection (a).

(c) The office or a contractor of the office shall pay a Medicaid claim submitted under this section at a rate equal to the highest rate of a state employee health plan, as defined in IC 5-10-8-6.6.".

Page 1, line 4, before "(3)" insert "**three**".

Page 1, line 11, delete "point-of-sale" and insert "**point of sale**".

Page 2, delete lines 33 through 42, begin a new paragraph and insert:

"SECTION 6. IC 12-19-7.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: Sec. 1. As used in this

chapter, "children's psychiatric residential treatment services" means services that are:

(1) eligible for federal financial participation under the state Medicaid plan; and

(2) provided to individuals less than twenty-one (21) years of age who are:

(A) eligible for services under the state Medicaid plan;

(B) approved by the office **as eligible** for admission to and treatment in a private psychiatric residential treatment facility; and

(C) **either** residing in a:

(i) private psychiatric residential facility for the purposes of treatment for a mental health condition, based on an approved treatment plan that complies with applicable federal and state Medicaid rules and regulations; **or**

(ii) less restrictive setting and participating in a federally approved community alternatives to psychiatric residential treatment facilities demonstration grant that provides safe, intensive, and appropriate services under an approved treatment plan that complies with federal and state Medicaid law.".

Delete page 3.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 566 as printed February 9, 2007.)

BROWN C, Chair

Committee Vote: yeas 8, nays 3.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred Senate Bill 566, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, delete lines 10 through 17.

Page 2, delete lines 1 through 12.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to ESB 566 as printed March 27, 2007.)

CRAWFORD, Chair

Committee Vote: yeas 20, nays 1.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 566 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-7-2-47.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 47.5. "Covered entity", for purposes of IC 12-15-23.5, has the meaning set forth in IC 12-15-23.5-1.**".

Page 1, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 3. IC 12-15-23.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 23.5. Coordination of Benefits Study

Sec. 1. As used in this chapter, "covered entity" has the meaning set forth in 45 CFR 160.103.

Sec. 2. Before January 1, 2008, the office shall:

(1) examine all Medicaid claims paid after January 1, 2001, and before July 1, 2007; and

(2) determine the percentage of the claims examined under subdivision (1) that were eligible for payment by a third party other than Medicaid.

The office may require, and a covered entity shall provide, any information necessary for the office to complete the examination required by this section. The office, after notice and hearing, may impose a fine not to exceed one thousand dollars ($1,000) for each refusal by a covered entity to provide information under this section.

Sec. 3. If the percentage determined under section 2 of this chapter is at least one percent (1%), the office shall develop and

implement a procedure to improve the coordination of benefits between:

(1) the Medicaid program; and

(2) any other third party source of health care coverage provided to a recipient.

Sec. 4. If a procedure is developed and implemented under section 3 of this chapter, the procedure:

(1) must be automated; and

(2) must provide a system for determining whether a Medicaid claim is eligible for payment by another third party before the claim is paid under the Medicaid program.".

Page 3, after line 22, begin a new paragraph and insert:

"SECTION 8. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to ESB 566 as printed April 3, 2007.)

WELCH

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 566 be amended to read as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning health care services.

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 11-12-5-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 8. (a) This section does not apply to a person subject to lawful detention who:**

(1) maintains a policy of insurance from a private company covering health care services; or

(2) is willing to pay for the person's own health care services.

(b) As used in this section, "lawful detention" has the meaning set forth in IC 35-41-1-18.

(c) A county shall reimburse:

(1) a physician licensed under IC 25-22.5;

(2) a hospital licensed under IC 16-21-2; or

(3) any other health care provider;

for health care services provided to a person subject to lawful

detention by the sheriff of the county. The reimbursement must be paid at a rate that is equal to the reimbursement rate that applies to health care services provided under a health care provider network contract with the county's health plan in which the most county employees are enrolled.

(d) The reimbursement paid under this section:

(1) must be equal to the reimbursement rate that the county health plan described in subsection (c) would pay after subtracting copayment amounts that would normally apply under the plan; and

(2) may not be reduced because of any deductible amounts or similar obligations owed under the county health plan.

(e) This section may not be construed to prevent or limit the application of IC 11-12-5-5 concerning the making of copayments by a person confined to a county jail.

(f) A county that is responsible for paying the medical care expenses of a county jail inmate under IC 11-12-5-6 is responsible paying the medical care expenses of the inmate under this section.

(g) This section may not be construed to supersede a written agreement:

(1) between:

(A) a physician, a hospital, or any other health care provider; and

(B) a county or sheriff;

concerning reimbursement for health care services provided to a person subject to lawful detention; and

(2) entered into or renewed before July 1, 2007.".

Page 3, after line 22, begin a new paragraph and insert:

"SECTION 7. IC 36-2-13-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ A FOLLOWS [EFFECTIVE JULY 1, 2007]: **Sec. 17. (a) This section does not apply to a person subject to lawful detention who:**

(1) maintains a policy of insurance from a private company covering health care services; or

(2) is willing to pay for the person's own health care services.

(b) As used in this section, "lawful detention" has the meaning set forth in IC 35-41-1-18.

(c) A sheriff of a county may not release a person subject to lawful detention solely for the purpose of preventing the county from being financially responsible under IC 11-12-5-8 for health care services provided to the person.

(d) If a county violates subsection (c), the county remains

financially responsible under IC 11-12-5-8 for health care services provided to the person released from lawful detention.

(e) A county is financially responsible under IC 11-12-5-8 for medical care provided to a person at a hospital if that person was subject to lawful detention by the sheriff at the time the person entered the hospital's premises.

(f) If a person is subjected to lawful detention after entering the premises of a hospital, the county in which the hospital is located is financially responsible under IC 11-12-5-8 for the medical care provided to the person while the person is subject to lawful detention.

(g) For purposes of this section, if a sheriff brings a person subject to lawful detention onto the premises of a hospital or subjects a person to lawful detention after the person enters the premises of a hospital, the sheriff shall remain on the premises of the hospital and within reasonable proximity to the person while the person receives medical care at the hospital unless:

(1) the person's medical condition renders the person incapable of leaving the hospital; and

(2) the person does not pose a threat to hospital personnel or property or to others at the hospital.

(h) This section may not be construed to prevent or limit the application of IC 11-12-5-5 concerning the making of copayments by a person confined to a county jail.

(i) A county that is responsible for paying the medical care expenses of a county jail inmate under IC 11-12-5-6 is responsible paying the medical care expenses of the inmate under this section.

(j) This section may not be construed to supersede a written agreement:

(1) between:

(A) a physician, a hospital, or any other health care provider; and

(B) a sheriff;

concerning reimbursement for health care services provided to a person subject to lawful detention; and

(2) entered into or renewed before July 1, 2007.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 566 as printed April 3, 2007.)

KUZMAN